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	17E071	A. BUILDING _____ B. WING _____	07/02/2013

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GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: The facility had a census of 26 residents with 16	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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residents selected for sample.

Based on observation, interview and record review, the facility failed to notify 1 of 16 residents' physicians when the resident experienced a minor injury as the result of a fall.

Findings included:

- Resident #2's clinical record included a 1-25-13 quarterly MDS (Minimum Data Set) assessment that identified the resident with no cognitive impairment and no falls since admission to the facility. A subsequent 4-27-13 quarterly MDS noted 1 fall with no injuries since the last assessment.

Review of the 7-25-13 fall CAA (Care Area Assessment) summary described resident #2 as unsteady with ambulation.

Review of the 5-9-13 care plan directed staff to check resident often to prevent falls.

Review of the nurses' notes revealed resident #2 sustained an unwitnessed fall on 4-18-13 at 10:30 a.m. when he/she tripped over the wheel of his/her wheelchair. Review of additional documentation revealed the resident received a bruise to the right palm, a skin tear to the right forearm, an abrasion to the right knee and to his/her forehead. Review of the clinical record revealed the resident did not require any treatment as a result of this fall. Further review of the clinical record revealed no evidence staff notified resident #2's physician of the fall with minor injuries which occurred on 4-18-13.

Observation on 6-24-13 at 3:00 pm revealed resident #2 transferred him/herself from the

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F 157	Continued From page 2 wheelchair to a straight backed chair in the small TV room down one hallway in the facility. The resident did not use the bell on table beside the straight back chair for any assistance before he/she transferred him/herself. During an interview on 6-25-13 at 3:30 pm, licensed nursing staff C stated it is facility policy to notify the resident's physician after each fall. During an interview on 6-26-13 at 2:30 pm, administrative staff A stated he/she expected the charge nurses to notify the family physician after a fall. Administrative nurse A confirmed staff did not notify the physician after resident #2 sustained a fall with minor injuries on 4-18-13. Review of the facility ' s Fall Policy dated 2-21-08 states, "In the event that a fall occurs: the attending or on call physician is notified if the assessment warrants." The facility failed to notify resident #2's physician after the resident experienced minor injuries as a result of a fall on 4-18-13.	F 157		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This Requirement is not met as evidenced by: The facility reported a census of 26 residents with 16 residents sampled. Based on interview and record review the facility failed to provide residents the right to receive mail	F 170		

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F 170	Continued From page 3 promptly and on Saturdays. Findings included: - The facility's undated Resident Rights information stated "residents have the right to send and receive mail promptly." During an interview on 6/25/13 at 1:30 p.m., Resident #5 reported that the facility does not deliver mail to the residents every Saturday. During an interview on 6/25/13 at 2:40 p.m., Activity Staff E stated that activity assistant M assisted with activities in the facility on most Saturdays and picked up and delivered the mail. Activity Staff E lacked awareness that the facility failed to deliver resident mail on Saturdays. During an interview on 6/25/13 at 4:30 p.m., direct care staff D revealed if Activity assistant M does not come to the facility on Saturdays, mail is not delivered. During an interview on 6/26/13 at 11:30 a.m., Administrative staff A revealed he/she lacked awareness that the facility failed to deliver resident mail on Saturdays. The facility failed to provide residents the right to receive mail promptly and on Saturdays.	F 170		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242		

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F 242	Continued From page 4 are significant to the resident. This Requirement is not met as evidenced by: The facility reported a census of 26 residents with 16 residents selected for sample. The sample included review of choices for 2 residents. Based on observation, interview and record review, the facility failed to allow 1 of 2 residents sampled for choices the right to choose bathing frequency/schedules. (Resident #25) Findings included: - Resident #25 ' s 8/16/12 admission MDS assessment identified his/her preferences related to choosing between a tub bath, shower, bed bath, or sponge bath as " very important " . Resident # 25's quarterly MDS (Minimum Data Set) assessment dated 5/19/2013 revealed the resident had a BIMS (brief interview for mental status) score of 15 which indicated intact cognition and he/she did not exhibit behaviors. The resident performed ADLs (activities of daily living) independently and required physical help in part of the bathing activity. The CAA (Care Area Assessment) summary completed on 8/16/2012 revealed the resident required supervision and cueing with ADLs secondary to poor decision making ability and required 1 person assist with bathing. The 6/13/2013 care plan noted resident # 25's choice for time to get up as "early" and time to go to bed at 10 p.m. The care plan lacked preferences for bathing frequency and choice of tub verses shower. The Care Plan stated	F 242		

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resident # 25 "wants to make his/her own decisions". The resident had the ability to respond appropriately and accurately to questions about his care and preferences.

During an observation on 6/24/2013 at 1:41 p.m. MST (Mountain Standard Time), resident # 25 exited the building independently through the door by the Rehab Room to a designated outside smoking area. He/she wore clean clothing and was clean shaven.

During an observation on 6/25/2013, at 12:45 p.m. MST the resident approached Direct Care Staff N, while seated at a dining room table. The resident asked Direct Care Staff N if he/she would be able to give him/her a bath today. Direct Care Staff N replied " No, my schedule is full. " Resident # 25 replied " I'm really going to miss that. "

During an interview on 6/24/2013, at 1:41 p.m. MST, resident # 25 reported he/she would like to have a shower or bath every other day. The resident identified Direct Care Staff N told him/her that his/her bath schedule was Monday, Wednesday, and Friday, 3 times per week. The resident reported asking for a bath every other day.

During an interview on 6/24/2013 at 1:41 p.m. MST, Direct Care Staff I reported Direct Care Staff N assigned the number of scheduled baths each week. Direct Care Staff I reported resident #25 performed ADLs independently, except for dressing after the bath.

During an interview on 6/26/2013 at 4:00 p.m. MST resident #25 reported he/she was not provided the scheduled shower on 6/24/2013 and

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F 242	Continued From page 6 was not provided a shower on 6/25/2013. During an interview on 6/26/2013, at 11:10 p.m. MST Licensed Nurse C reported the nurse asks residents on admission of their choices related to frequency of bathing. Nurse C reported the desired bath frequency would be documented on the admission record. Review of resident #25 ' s admission record lacked documentation related to his/her bathing preferences. The facility failed to allow resident #25 the right to choose bathing frequency and time of day he/she received the baths.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility had a census of 26 residents with 16 residents selected to sample. The sample included review of activities for 3 residents. Based on observation, interview and record review, the facility failed to provide an ongoing program of activities (evening and weekend) and an individualized activity program for 1 of the 3 residents sampled for activities. (#25) Findings included: - An Admission MDS (minimum data set) assessment dated 8/16/2012 revealed the resident had a BIMS (brief interview for mental	F 248		

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F 248	Continued From page 7 status) score of 12 which indicated moderately impaired cognition. The assessment further identified activity preferences of books, newspapers, magazines, music, animals/pets, keeping up with news, favorite activities, and going outside for fresh air, all as " very important " . The assessment indicated the resident viewed group activities as " not very important " . The Cognitive Loss CAA (Care Area Assessment) summary completed on 8/16/2012 identified resident #25 as having confusion and forgetfulness when visiting with staff. The resident required supervision and cuing with ADLs (Activities of Daily Living) secondary to poor decision making ability. Resident #25 care plan dated 6/3/2013, identified that the resident liked to make his/her own decisions, chooses to follow the routine he/she set for him/herself, enjoyed talking to people, liked dogs and wanted to be notified if a dog visited the facility. The nursing care plan included the goal: " To make decisions in my life and cares for as long as I can. I don ' t want my depression to worsen so invite me to activities. " Resident #25 ' s care plan also included interests such as jazz music, gardening, reminiscing, helping others, parties/social events, reading/writing, loves being outdoors, and identified his/her favorite animal as a Cairn Terrier (a breed of dog that the resident formerly had as a pet). The care plan also indicated the resident preferred activities in his/her room or outside in the courtyard. Review of Activity Assessment dated 10/15/2012 identified activity interests as stated in the care plan and also included crossword puzzles.	F 248		

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Resident #25 ' s June 2013 Activity Log documented he/she accepted one on one daily visits and watched TV daily. The log also included refusals of games, trivia, coffee/chat each week, reading magazines, and church each week. An entry on 5/30/13 by activity staff stated the resident lacked interest in outings, coffee/chat and enjoyed keeping to him/herself and going outside.

Review of the June 2013 Activity Calendar revealed no evening activities scheduled from Monday through Friday, with the exception of a barbecue scheduled at 5:30 p.m. on 6/28/2013. The calendar also included poker scheduled each Saturday at 2:00 p.m. and a movie at 6:30 p.m. with church scheduled each Sunday at 1:30 p.m.

During an observation on 6/25/2013 at 10:30 a.m. resident #25 attended group exercise and actively participated.

An observation on 6/25/13 at 2:30 p.m. revealed resident #25 sleeping in his/her room. At 3:30 p.m. he/she ambulated independently to the activity room area for an iced coffee.

During an interview on 6/24/203 at 11:00 a.m., resident #25 reported he would like to lift weights as an activity. He reported there were no evening or weekend activities. He/she stated the only evening activity he/she remembered was " going on a van ride to look at the Christmas lights " . He/she verbalized " I have learned to watch TV. "

During an interview on 6/24/2013 at 2:45 p.m. the activity staff E reported another resident had the responsibility of starting the scheduled weekend movie activity. He/she confirmed the resident assigned to start the movie had difficulty with the

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F 248	Continued From page 9 equipment and staff did not ensure the activity occurred. During an interview on 6/25/2013 at 10:15 a.m., Direct Care Staff D reported staff did not cue resident #25 prior to activities. He/she stated the resident liked to smoke and stay in his/her room. During an interview on 6/25/2013 at 11:10 a.m., Licensed Nurse C confirmed the facility did not offer other evening or weekend activities other than Bible study. The nurse reported there was no documentation for resident attendance of evening or weekend activities because the activities did not happen. The facility failed to provide an individualized activity program to meet resident #25's needs and interests. The facility also failed to offer evening and weekend activities.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278		

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F 278	Continued From page 10 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility reported a census of 26 residents with 16 residents sampled for review. Based on observation, interview, and record review, the facility failed to accurately assess 1 of the 16 sampled residents related to falls and community discharge. (Resident #30) Findings included: - Resident #30's 4/24/13 physician's orders included orders to admit the resident to the facility on 4/24/13 for rehabilitation after an acute (a disease characterized by a relatively sudden onset of symptoms that are usually severe) hospital stay. The physician's orders included diagnoses of a right humeral head/neck fracture (broken bone of the upper arm) and a right femoral neck fracture (broken top of thigh bone that attached to the hip) dated 3/22/13. Resident #30's 5/7/13 Admission MDS (Minimum Data Set) Assessment reported no cognitive impairment and the resident independently performed activities of daily living except bathing in which 1 staff provided extensive assistance. The MDS reported the resident experienced a	F 278		

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fracture (broken bone) labeled as "other" and did not indicate that the resident broke his/her hip. The MDS failed to report that the resident experienced a fall either 1 month or between 2 to 6 months prior to admission and failed to indicate the resident experienced fractured bones from the fall. The MDS reported the resident had an active plan to discharge but failed to report if the resident planned to discharge to the community or to another facility. Due to the failure to indicate that the resident fell prior to admission and failure to indicate where the resident planned to discharge, the MDS did not trigger further investigations into falls or community discharge.

Resident #30's 6/20/13 care plan instructed staff to assist the resident with dressing his/her lower half of the body if the resident asked for assistance and walked independent with a cane. The care plan reported that the resident's strength improved since admission and had a goal to take care of his/her own needs with assistance available if the resident needed it. The care plan reported that the resident planned to stay in the facility approximately 4 weeks or less then return to his/her apartment after family members helped prepare for his/her arrival.

During an observation on 6/24/13 at 3:45 p.m. MST (Mountain Standard Time), resident #30 stood up and walked independently using a cane without difficulty and displayed no outward signs of pain such as grimacing or moaning.

During an interview on 6/24/13 at 3:45 p.m. MST, resident #30 reported that several months ago, he/she fell while trying to avoid a car as he/she walked to work and broke his/her right upper arm and right hip. The resident stated "I am a quick healer" but still experienced limitations in bending

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F 278	Continued From page 12 his/her right hip. The resident reported he/she planned to return to his/her apartment after family members adjusted the shower "so I won't have to bend my leg up that high". During an interview on 6/26/13 at 10:50 a.m. MST, Administrative Nursing Staff B verified the resident's MDS lacked information about the fall with fractures prior to admission and plans to discharge to the community. The facility failed to assess resident #30's Admission MDS accurately related to his/her fall with fractures prior to admission and plans to discharge to the community.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	Continued From page 13 This Requirement is not met as evidenced by: The facility reported a census of 26 residents with 16 residents sampled for review and 4 residents reviewed for falls. Based on observation, interview, and record review, the facility failed to review/revise 3 of the 4 sampled residents' care plans to prevent further falls. (Residents #19, #29, and #2) Findings included: - Resident #19's 11/9/12 Annual MDS (Minimum Data Set) Assessment reported the resident had difficulty understanding others/made him/herself understood with moderately impaired cognition. The MDS reported the resident independently transferred and moved in bed, needed supervision of one staff for toileting, and used a walker. The MDS reported the resident fell once without injury since the previous assessment. Resident #19's 2/9/13 Quarterly MDS Assessment reported the resident usually understood others and made him/herself understood with moderately impaired cognition. The MDS reported the resident independently moved in bed, transferred, and toileted, used a walker, and experienced no falls since the last assessment. Resident #19's 6/12/13 Significant Change of Status MDS reported the resident left the facility to an acute hospital on 5/2/13 and returned on 5/30/13. The MDS reported the resident sometimes understands others and sometimes made him/herself understood with severely impaired cognition. The MDS reported the resident needed supervision assistance of one staff for bed mobility, limited assistance of one	F 280		

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staff for transfers, and extensive assistance of one staff for toilet use. The MDS reported the resident used a walker and a wheelchair and experienced no falls since the last assessment.

Resident #19's 11/9/12 Falls CAA (Care Area Assessment) summary reported the resident stated he/she had a vivid dream that a snake pushed her from his/her chair which caused the resident to fall without injury on 10/13/12. The CAA reported the resident posed as high risk for falling due to use of multiple medications such as Seroquel (an antipsychotic medication) and Lasix (a diuretic medication) and independent use of a front wheeled walker.

Resident #19's 6/13/13 Falls CAA summary reported the resident experienced no recent falls but posed as high risk for falls due to recent changes in his/her functioning ability and needed more assistance with activities of daily living. The CAA reported that staff utilized an alarm to activate if the resident attempted to transfer him/herself.

Resident #19's 3/4/13 care plan, last reviewed on 6/4/13, informed staff that the resident's last fall assessment ranked as "17" which put the resident as a high risk for falls. The care plan informed staff the resident experienced a few falls in the past and if the resident complains of feeling dizzy to take the resident's vital signs, report this to the charge nurse, and watch the resident closely when he/she walked independently with a walker as staff may need to use a gait belt to assist the resident to walk. The care plan reported the resident had a history of developing urinary tract infections which increased his/her risk of falling due to increased dizziness and confusion. The care plan instructed to keep the

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resident's room free of clutter, call light within reach, and ensure the resident's footwear had non-slip surfaces. The care plan instructed to keep the resident's bed in the lowest position and the bed wheels locked to keep the resident from slipping out of bed. The care plan included an update on 5/31/13 instructing that 2 staff needed to assist the resident with transfers and to use a sit-to-stand lift if necessary but lacked mention of use of gait belts with transfers. Dates of falls listed on the care plan included the 10/13/12 fall and reported the resident "was found on floor by staff next to the bed". The care plan lacked mention of the resident's fall on 6/22/13 and lacked an intervention to prevent further falls on 10/13/12 and 6/22/13.

Review of resident #19's nurses' notes revealed the resident fell on 10/13/12 and 6/22/13 with no injuries.

Review of resident #19's nurses' notes revealed that staff found the resident on the floor laying on his/her left side on 6/22/13 at 8:45 a.m. The nurse's note reported the resident had no injury and the resident stated he/she "had mis-stepped and missed the bed". Further nurses' notes revealed staff notified the physician and the resident's fall of the 6/22/13 fall and staff assessed the resident's vital signs and condition for the next 72 hours.

During an observation on 6/25/13 at 12:33 p.m. MST, Direct Care Staff D and Licensed Nursing staff C assisted the resident to use the toilet but failed to use a gait belt during the transfer. The resident held the bathroom grab bar during the transfer and stood in a steady manner, but could not stand up or sit down without Staff D assisting by holding under the resident's arm. Further

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observations revealed a gait belt hung on a loop on the back of the bathroom door.

During an interview on 6/26/13 at 11:01 a.m. MST, Administrative Nursing Staff B reported the facility expected the charge nurse to update the care plan with an intervention to prevent further falls.

The facility's "Fall Policy", last revised on 2/21/08, instructed staff to make "necessary changes to the resident's plan of care shall be implemented immediately" after a resident falls.

The facility failed to review/revise resident #19's care plan after falls on 10/13/12 and 6/22/13 to prevent further falls.

- Resident #2's clinical record included a 1-25-13 quarterly MDS (Minimum Data Set) assessment that identified the resident with no cognitive memory impairment and no falls since admission to the facility. A subsequent 4-27-13 quarterly MDS noted 1 fall with no injuries since the last assessment.

Review of the 7-25-13 fall CAA (Care Area Assessment) summary described resident #2 as unsteady with ambulation.

Review of the 5-9-13 care plan listed a variety of fall prevention strategies such as, keep bell beside recliner, need reminder not to pick up things off floor, check shoes and slippers, check surrounding area to keep free of clutter, check often, and lock brakes on wheelchair. The care plan listed the resident fell on the following dates: 2-4-13, 3-1-13, and 4-18-13. The care plan did not state when facility staff initiated the above

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F 280	Continued From page 17 interventions. Review of the 4-27-13 fall risk assessment identified resident #2 as high risk for falls. Review of the nurses' notes lacked documentation regarding the fall resident #2 sustained on 2-4-13. Although requested, the facility failed to provide evidence of additional documentation related to this fall on 2-4-13. Review of the clinical record revealed the resident sustained an unwitnessed fall on 4-18-13 when he/she tripped over the wheel of his/her wheelchair. Review of additional documentation revealed the resident received a bruise to the right palm, a skin tear to the right forearm, an abrasion to the right knee and to his/her forehead. Further review of the clinical record revealed a fall intervention sheet in the resident's chart with an intervention to "encourage to ask for help when needed " after falls on 3/1/13 and 4/18/13. Review of the nurses' notes on 6-10-13 at 12:00 p.m. revealed staff found resident #2 on the floor as a result of a fall that resulted in a 2 cm x 0.3 cm laceration on his/her head that did not require medical treatment. Observation on 6-24-13 at 3:00 pm revealed resident #2 transferred him/herself from the wheelchair to a straight backed chair in the small TV room down one hallway in the facility. The resident did not use the bell on table beside the straight back chair for any assistance before he/she transferred him/herself. During an interview on 6-25-13 at 3:30 p.m.,	F 280		

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F 280	Continued From page 18 licensed nursing staff C stated it is facility policy to investigate the cause of the fall and initiate a new intervention after each fall. During an interview on 6-26-13 at 1:30 p.m., administrative staff A stated he/she expected staff to update the care plan with new interventions after each fall. Administrative nurse A confirmed staff failed to update resident #2's care plans with new interventions after falls sustained on 2-4-13, 4-18-13 or 6-10-13. Review of the facility's fall policy dated 2-21-08 states, "Necessary changes to the resident plan of care shall be implemented immediately". The facility failed to update the care plan with new interventions to help prevent further falls for resident #2. - Resident #29's., 4/13/13 admission MDS (minimum data set) revealed a BIMS (brief interview for mental status) which indicated severely impaired cognitive skills. The assessment also revealed the resident required supervision with transfers, walking in room and toileting. The assessment further revealed that resident #29 was not steady but able to stabilize without staff assist when moving from a sitting to standing position, turning around and transfer from surface to surface. The assessment also revealed the resident had no issues with range of motion in upper or lower extremities and was continent of bladder and bowel. The assessment also revealed the resident had one fall since admission. Resident #29's CAA (care area assessment) summary dated 4/14/13 triggered for falls stating	F 280		

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that the resident was at risk for falls due to a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion) and being a new admission to the facility. The assessment revealed that the resident had a motion alarm placed, that staff needed to visually check on the resident frequently and assist with activities of daily living.

The 6/4/13 revised nursing care plan for resident #29 alerted staff that any resident newly admitted to the facility should considered at risk for falls, for staff to check shoes and slippers to ensure they have a non-slip surface and to keep bed in lowest position. The care plan noted that on 4/20/13 the resident slid out of chair when his/her family did not notify staff that the resident had been placed in his/her room, therefore no alarm had been placed on resident #29. The care plan revealed that family had been notified to let the facility staff know when they are leaving the building. The nursing care plan further revealed to staff on 6/4/13 that resident #29 ambulated with two assist and had an alarm placed on wheelchair, recliner and bed. The care plan lacked interventions to prevent future falls after falls sustained on 4/10/13, 4/21/13, 4/27/13, 5/3/13 (two falls), 5/7/13, 5/24/13 ,5/26/13, 6/4/13, 6/8/13, 6/9/13, and 6/20/13.

Resident #29's fall assessment dated 2/17/13 identified resident as " high risk " for falls.

According to resident #29's physician standing orders if a fall occurred the staff should notify the physician, evaluate for causes, fill out the fall evaluation sheet, put in the medical record and make a copy for the DON (director of nursing).

Review of the fall investigation form revealed that

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falls took place on 4/10/13, 4/20/13, 4/27/13, 5/3/13, 5/26/13, 6/9/13, and 6/18/13 and review of the clinical record revealed no evidence of update of the care plan to prevent future falls.

The facilities fall policy with a revision dated of 10/19/09 directed staff that if a fall occurs to make necessary changes to the resident plan of care immediately.

Observation on 6/25/13 at 8:06 a.m., Resident #29 sat at the dining room table, with feet resting on floor and a beeper alarm pad noted in resident's wheel chair.

During an interview on 6/25/13 at 4:24p.m., direct care staff D revealed the resident #29 had alarms placed in wheelchair, recliner or bed at all times and staff should keep the resident in a well-populated areas. Staff D further revealed that resident #29 attempts to transfer herself/himself and that he/she had a hard time judging distance.

During an interview on 6/26/13 at 10:20 a.m., Administrative staff B revealed that resident #29 liked to self-transfer and staff should keep the resident in eye contact. Administrative staff B further revealed that at the time of fall the charge nurses should update the care plan with an appropriate intervention.

During an interview on 6/26/13 at 11:16 a.m., Administrative nurse A revealed that he/she expected the charge nurse to update the care plan with an appropriate intervention following a fall and confirmed the care plans were not updated.

The facility failed to review/revise resident #29's

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F 280	Continued From page 21 care plan with appropriate fall prevention strategies after multiple falls.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 26 residents with 16 sampled for review. The sample included review of falls for 4 residents. The facility identified 6 residents as cognitively impaired and independently mobile. Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained free of accident/hazards for 6 of 6 cognitively impaired, independently mobile residents when staff stored potentially hazardous chemicals in areas accessible to the residents. Based on observation, interview, and record review, the facility also failed to ensure the resident environment remained free of accident/hazards (unlocked dining room doors leading to unsecured concrete stairs and an alcove area not within visualization of staff) for 6 of 6 residents identified as cognitively impaired and independently mobile. Based on observation, interview, and record review the facility also failed to ensure 3 of 4	F 323		

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residents sampled for falls received adequate supervision to prevent accidents/falls. (#19 , #29, #2)

Findings included:

- During an observation on 6/24/13 at 10:29 a.m. MST (Mountain Standard Time) the door to the common shower room opened with a key located in the lock of the door. The shower room contained the following unsecured chemicals:
* Power clean pre-disinfectant , 1 gallon, 1/2 full, labeled "Keep out of reach of children."
* Cid-a-l II disinfectant cleaner, 1 gallon, full, labeled "Keep out of reach of children."
* 3m HB Quat disinfectant cleaner, full 1 liter spray bottle, labeled "eye, skin, nose irritant"

An observation on 6/25/13 at 11:00 a.m. MST revealed the common shower room locked without the key in the door.

During an interview on 7/1/13 at 1:11 a.m. MST administrative nurse A reported the facility expected staff to lock potentially hazardous chemicals in a cabinet in the common shower when they leave the room.

Although requested, the facility failed to provide a policy or procedure for chemical storage.

The facility failed to ensure an environment free of accident/hazards when staff stored potentially harmful chemicals in areas accessible to 6 cognitively impaired, independently mobile residents.

- Resident #11's 5/12/13 quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental

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status) score of 5 which indicated severe cognitive impairment and walked independently in the corridor and his/her room.

Resident #11's 11/9/12 CAA (care area assessment) summary for cognitive loss stated the resident had confusion to place/time and referred to nurses' notes for documentation of episodes of confusion. The CAA summary also stated the resident often looked for his/her "young son or parents".

The 5/20/13 nursing care plan for resident #11 identified the resident had a memory problem and stated, "I am very forgetful and...easily confused". The care plan further stated the resident looked for his/her parents and for a "lost boy". The resident's mobility care plan stated, "I ambulate around the facility independently. I do need supervision to go places that are not here in the building."

An observation on 6/24/13 at 10:45 a.m. MST (Mountain Standard Time) in the dining room area revealed two sets of unlocked double doors leading to an enclosed concrete courtyard/patio area. The courtyard had a metal gate/fenced area that led to a cement stairway. During the observation, the gate the led to the stairs opened easily, making the stairway easily accessible to residents. The courtyard also had a cemented alcove area with a barbecue grill on the west side of the building, not within visualization from the dining room.

During an observation on 6/25/13 at 4:21 p.m. MST, resident #11 stood by one of the double doors in the dining room area, opened the door, and stood in the doorway for a moment, then came back inside.

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F 323	Continued From page 24 An observation on 6/26/13 at 8:20 a.m. MST revealed the gate to the stairway in the courtyard area in a secured, locked position. During an interview on 6/25/13 at 5:30 p.m. MST, administrative nurse A stated the gate to the stairway in the courtyard should be locked and also revealed the dining room doors remained unlocked, even at night without constant visualization of staff. The facility identified 6 cognitively impaired, independently mobile residents with access to the facility courtyard. During an interview on 6/26/13 at 8:30 a.m. MST administrative staff A confirmed that maintenance staff bolted the gate to the stairs in the courtyard to ensure residents would not have access to the stairway. An interview on 6/26/13 at 10:14 a.m. MST with direct care staff H revealed resident #11 frequently went in to the dining room courtyard area unattended. On 6/26/13 at 3:00 p.m. MST maintenance staff G stated he/she was installing a gate to the alcove area in the courtyard to ensure the residents in the courtyard would be visible to staff. He/she stated the gate would be installed on 6/26/13. The facility failed to ensure an environment free of accident/hazards for 6 cognitively impaired, independently mobile residents with access to the facility courtyard. The facility dining room had 2 unlocked double doors leading to a courtyard with an unlocked gate that led to concrete stairs and a cement alcove area on the west side of the building that was not visible to staff in the dining	F 323		

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F 323	Continued From page 25 room area. - Resident #19's 11/9/12 Annual MDS (Minimum Data Set) Assessment reported the resident had difficulty understanding others/made him/herself understood with moderately impaired cognition. The MDS reported the resident independently transferred and moved in bed, needed supervision of one staff for toileting, and used a walker. The MDS reported the resident fell once without injury since the previous assessment. Resident #19's 2/9/13 Quarterly MDS Assessment reported the resident usually understood others and made him/herself understood with moderately impaired cognition. The MDS reported the resident independently moved in bed, transferred, and toileted, used a walker, and experienced no falls since the last assessment. Resident #19's 6/12/13 Significant Change of Status MDS reported the resident left the facility to an acute hospital on 5/2/13 and returned on 5/30/13. The MDS reported the resident sometimes understands others and sometimes made him/herself understood with severely impaired cognition. The MDS reported the resident needed supervision assistance of one staff for bed mobility, limited assistance of one staff for transfers, and extensive assistance of one staff for toilet use. The MDS reported the resident used a walker and a wheelchair and experienced no falls since the last assessment. Resident #19's 11/9/12 Falls CAA (Care Area Assessment) summary reported the resident stated he/she had a vivid dream that a snake pushed her from his/her chair which caused the	F 323		

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resident to fall without injury on 10/13/12. The CAA reported the resident posed as high risk for falling due to use of multiple medications such as Seroquel (an antipsychotic medication) and Lasix (a diuretic medication) and independent use of a front wheeled walker.

Resident #19's 6/13/13 Falls CAA summary reported the resident experienced no recent falls but posed as high risk for falls due to recent changes in his/her functioning ability and needed more assistance with activities of daily living. The CAA reported that staff utilized an alarm to activate if the resident attempted to transfer him/herself.

Resident #19's 3/4/13 care plan, last reviewed on 6/4/13, informed staff that the resident's last fall assessment ranked as "17" which put the resident as a high risk for falls. The care plan informed staff the resident experienced a few falls in the past and if the resident complains of feeling dizzy to take the resident's vital signs, report this to the charge nurse, and watch the resident closely when he/she walked independently with a walker as staff may need to use a gait belt to assist the resident to walk. The care plan reported the resident had a history of developing urinary tract infections which increased his/her risk of falling due to increased dizziness and confusion. The care plan instructed to keep the resident's room free of clutter, call light within reach, and ensure the resident's footwear had non-slip surfaces. The care plan instructed to keep the resident's bed in the lowest position and the bed wheels locked to keep the resident from slipping out of bed. The care plan included an update on 5/31/13 instructing that 2 staff needed to assist the resident with transfers and to use a sit-to-stand lift if necessary but lacked mention of

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F 323	Continued From page 27 use of gait belts with transfers. Dates of falls listed on the care plan included the 10/13/12 fall and reported the resident "was found on floor by staff next to the bed". The care plan lacked mention of the resident's fall on 6/22/13 and lacked an intervention to prevent further falls on 10/13/12 and 6/22/13. Review of resident #19's "Fall Risk Assessment" form reported the resident scored as "11" on 12/9/12, "17" on 2/19/13, and "20" on 6/17/13 with indication that residents who scored 7 or higher posed as high risk for falling. Review of resident #19's nurses' notes revealed staff found the resident on the floor laying on his/her right side on 10/13/12 at 1:15 a.m. MST (Mountain Standard Time). The nurse's note reported staff noted a facial tissue in the resident's nose with a small amount of blood and a small abrasion on the left side of his/her nose but no other injury. The nurse's note report the resident stated he/she saw snakes in the closet and stated he/she "must have been dreaming". Further nurse's notes revealed the physician and the resident's family received notification of the 10/13/12 fall and staff assessed the resident's vital signs and condition for the next 72 hours. Review of resident #19's nurses' notes revealed that staff found the resident on the floor laying on his/her left side on 6/22/13 at 8:45 a.m. The nurse's note reported the resident had no injury and the resident stated he/she "had mis-stepped and missed the bed". Further nurses' notes revealed staff notified the physician and the resident's fall of the 6/22/13 fall and staff assessed the resident's vital signs and condition for the next 72 hours.	F 323		

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Review of resident #19's 4/5/13 physician's standing orders revealed "notify the physician of any fall, if no apparent injury call the clinic or fill out a communication sheet and fax it to the clinic to the physician. Vital signs are to be done every shift for 72 hours on non-inury falls or accidents. If the fall occurs, notify the physician, evaluate the causes of the fall, complete an evaluation sheet and send a copy to the Director of Nursing. For head injuries, follow up with vital signs including Glasgow Coma Scale [a scale to evaluate alertness] every 15 minutes for one hour, then every hour for 4 hours, then every shift for the remaining 72 hours."

During an observation on 6/25/13 at 12:33 p.m. MST, Direct Care Staff D and Licensed Nursing staff C assisted the resident to use the toilet but failed to use a gait belt during the transfer. The resident held the bathroom grab bar during the transfer and stood in a steady manner, but could not stand up or sit down without Staff D assisting by holding under the resident's arm. Further observations revealed a gait belt hung on a loop on the back of the bathroom door.

During an interview on 6/25/13 at 9:31 a.m. MST, Direct Care Staff I reported that staff passed on in verbal report that the resident fell recently but could not recall when, that the alarm in his/her bed activated, and that the resident had attempted to transfer without assistance. Staff I reported he/she worked at the facility for the last few months, did not recall the resident had any other falls, and staff used an alarm on his/her wheelchair and bed due to the resident's high risk for falling.

During an interview on 6/25/13 at 12:34 p.m. MST, Direct Care Staff D reported that staff

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transferred the resident with use of a gait belt but he/she could not find one prior to the transfer. Staff D recalled that staff found the resident on the floor recently and had not fallen since the end of last year, neither fall with injuries.

During an interview on 6/25/13 at 12:36 p.m. MST, Licensed Nursing Staff C reported the facility expected staff to utilitize a gait belt while helping resident #19 to transfer.

During an interview on 6/26/13 at 11:01 a.m. MST, Administrative Nursing Staff B reported the facility expected the charge nurse to update the care plan with an intervention to prevent further falls. Staff B reported the facility expected staff to assess a resident's neurological condition only if staff suspected a head injury and agreed that due to the fact no one witnessed resident #19's 10/13/12 and 6/22/13 falls and the resident's cognition fluctuated, staff should suspect a possible head injury with unwitnessed falls.

The facility's "Fall Policy", last revised on 2/21/08, instructed staff that all residents admitted to the facility posed a risk to fall due to change in environment and predisposing diseases and staff will complete each resident's care plan with interventions to prevent falls, including assessments of the ability to use the call light and how much assistance the resident needed for toileting. The policy instructed staff to ulitlize gait belts with ambulation but lacked instructions on how to assist a resident with transfers. The policy instructed staff to use bed and chair alarms for residents who posed as high risk for falls and "necessary changes to the resident's plan of care shall be implemented immediately" after a resident falls. The policy lacked instructions related to unwitnessed falls.

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F 323	Continued From page 30 The facility failed to ensure resident #19's received adequate supervision to prevent accidents as staff failed to utilize a gait belt during a transfer and staff failed to revise the resident's care plan to prevent further falls. - Resident #29's 4/13/13 admission MDS (minimum data set) revealed a BIMS (brief interview for mental status) which indicated severely impaired cognitive skills. The assessment also revealed the resident required supervision with transfers, walking in room and toileting. The assessment further revealed that resident #29 was not steady but able to stabilize without staff assist when moving from a sitting to standing position, turning around and transfer from surface to surface. The assessment also revealed the resident had no issues with range of motion in upper or lower extremities and was continent of bladder and bowel. The assessment also revealed the resident had one fall since admission. Resident #29's CAA (care area assessment) summary dated 4/14/13 triggered for falls stating that the resident was at risk for falls due to a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion) and being a new admission to the facility. The assessment revealed that the resident had a motion alarm placed, that staff needed to visually check on the resident frequently and assist with activities of daily living. The 6/4/13 revised nursing care plan for resident #29 alerted staff that any resident newly admitted to the facility should considered at risk for falls, for staff to check shoes and slippers to ensure	F 323		

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they have a non-slip surface and to keep bed in lowest position. The care plan noted that on 4/20/13 the resident slid out of chair when his/her family did not notify staff that the resident had been placed in his/her room, therefore no alarm had been placed on resident #29. The care plan revealed that family had been notified to let the facility staff know when they are leaving the building. The nursing care plan further revealed to staff on 6/4/13 that resident #29 ambulated with two assist and had an alarm placed on wheelchair, recliner and bed. The care plan lacked interventions to prevent future falls after falls sustained on 4/10/13, 4/21/13, 4/27/13, 5/3/13 (two falls), 5/7/13, 5/24/13 ,5/26/13, 6/4/13, 6/8/13, 6/9/13, and 6/20/13.

Resident #29's fall assessment dated 2/17/13 identified resident as "high risk" for falls.

According to resident #29's physician standing orders if a fall occurred the staff should notify the physician, evaluate for causes, fill out the fall evaluation sheet, put in the medical record and make a copy for the DON (director of nursing).

Review of the fall investigation form revealed that falls took place on 4/10/13, 4/20/13, 4/27/13, 5/3/13, 5/26/13, 6/9/13, and 6/18/13 and review of the clinical record revealed no evidence of update of the care plan to prevent future falls.

The facilities fall policy with a revision dated of 10/19/09 directed staff that if a fall occurs to make necessary changes to the resident plan of care immediately.

Observation on 6/25/13 at 8:06 a.m., Resident #29 sat at the dining room table, with feet resting on floor and a beeper alarm pad noted in resident

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F 323	Continued From page 32 ' s wheel chair. During an interview on 6/25/13 at 4:24 p.m., direct care staff D revealed the resident #29 had alarms placed in wheelchair, recliner or bed at all times and staff should keep the resident in a well-populated areas. Staff D further revealed that resident #29 attempts to transfer herself/himself and that he/she had a hard time judging distance. During an interview on 6/26/13 at 10:20 a.m., Administrative staff B revealed that resident # 29 liked to self-transfer and staff should keep the resident in eye contact. Administrative staff B further revealed that at the time of fall the charge nurses should update the care plan with an appropriate intervention. During an interview on 6/26/13 at 11:16 a.m., Administrative nurse A revealed that he/she expected the charge nurse to update the care plan with an appropriate intervention following a fall and confirmed the care plans were not updated. The facility failed to implement appropriate fall prevention strategies after resident #29 sustained multiple falls on 4/10/13, 4/21/13, 4/27/13, 5/3/13 (two falls), 5/7/13, 5/24/13 ,5/26/13, 6/4/13, 6/8/13, 6/9/13, and 6/20/13. - Resident #2's clinical record included a 1-25-13 quarterly MDS (Minimum Data Set) that identified the resident with no cognitive impairment and no falls since admission to the facility. A subsequent 4-27-13 quarterly MDS noted 1 fall with no injuries since the last assessment.	F 323		

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Review of the 7-25-13 fall CAA (Care Area Assessment) summary described resident #2 as unsteady with ambulation.

Review of the 5-9-13 care plan listed a variety of fall prevention strategies such as keep bell beside recliner, need reminder not to pick up things off floor, check shoes and slippers, check surrounding area to keep free of clutter, check often, and lock brakes on wheelchair. The care plan listed the resident fell on the following dates: 2-4-13, 3-1-13, and 4-18-13. The care plan did not state when facility staff initiated the above interventions.

Review of the 4-27-13 fall risk assessment identified resident #2 as " high risk " for falls.

Review of the nurses' notes lacked documentation regarding the fall resident #2 sustained on 2-4-13. Although requested, the facility failed to provide evidence of additional documentation related to the fall on 2-4-13.

Review of the clinical record revealed the resident sustained an unwitnessed fall on 4-18-13 when he/she tripped over the wheel of his/her wheelchair. Review of additional documentation revealed the resident received a bruise to the right palm, a skin tear to the right forearm, an abrasion to the right knee and to his/her forehead. He/she did not require medical treatment after the fall.

Further review of the clinical record revealed a fall intervention sheet in the resident's chart with an intervention to "encourage to ask for help when needed" after falls on 3-1-13 and 4-18-13.

Review of the nurses ' notes on 6-10-13 at 12:00

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F 323	Continued From page 34 pm revealed staff found resident #2 on the floor as a result of a fall that resulted in a 2 cm x 0.3 cm laceration on his/her head that did not require medical treatment. Observation on 6-24-13 at 3:00 pm revealed resident #2 transferred him/herself from the wheelchair to a straight backed chair in the small TV room down one hallway in the facility. The resident did not use the bell on table beside the straight back chair for any assistance before he/she transferred him/herself. During an interview on 6-25-13 at 3:30 pm, licensed nursing staff C stated it is facility policy to investigate the cause of the fall and initiate a new intervention after each fall. During an interview on 6-26-13 at 1:30 pm, administrative staff A stated he/she expected staff to update the care plan with new interventions after each fall. Administrative nurse A confirmed staff failed to update resident #2's care plan with new interventions after falls sustained on 2-4-13, 4-18-13, and 6-10-13. Review of the facility's fall policy dated 2-21-08 states, "Necessary changes to the resident plan of care shall be implemented immediately". The facility failed to implement interventions to reduce the risk of further falls for resident #2 who sustained multiple falls.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

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F 329	Continued From page 35 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility reported a census of 26 with 10 residents reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure that 7 of 10 residents did not receive unnecessary medications, when staff failed to monitor target behaviors for resident #8, 24, 22 and 19, who received psychoactive medications. The facility also failed to notify the physician of blood pressures out of target parameters for resident #15, #29 and #9. Findings included: - Resident #15 5/1/13 medication order sheet revealed orders for:	F 329		

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F 329	Continued From page 36 Toprol (an anti-hypertensive used to lower blood pressure) 25mg (milligrams) every day for Hypertension (elevated blood pressure). Lisinopril (an anti-hypertensive) 50mg every day for Hypertension Resident #15's 4/23/13 Quarterly MDS (minimum data set) revealed the resident had a BIMS (brief interview for mental status) score which indicated severe cognitive impairment. Resident #15's 5/9/13 revised nursing care plan advised staff to monitor blood pressure parameters for the use of Toprol. Standing orders dated 4/4/13 directed staff to notify the primary physician if a resident ' s systolic blood pressure (top number) registered less than 90mmHg (millimeters of mercury) or greater than 170 mmHg and if the diastolic blood pressure (bottom number) registered less than 50mmHg or greater than 100 mmHg. The clinical record revealed the following blood pressure readings with none of the readings. * 2/15/13: 194/87mmHg * 2/15/13: 197/106 mmHg * 4/7/13: 186/89 mmHg * 4/30/13: 183/186 mmHg * 5/4/13: 189/97 mmHg * 5/20/13: 191/190 mmHg * 5/31/13: 192/91 mmHg * 6/1/13: 185/104 mmHg Review of the clinical record revealed a lack of documentation in the nurse's notes or documentation of physician notification of the elevated blood pressures, above the parameters established in the facility standing orders.	F 329		

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F 329	Continued From page 37 An observation on 6/25/13 at 4:15p.m. MST (Mountain Standard Time), Resident #15 ambulated down the hallway independently, his/her gait remained steady. During an interview on 6/26/13 at 10:14 a.m. MST, Administrative staff B revealed that if a resident ' s blood pressure reading registers out of the parameters set by the physician, then staff should notify the physician by phone or fax. During an interview on 6/26/13 at 11:20 a.m. MST, Administrative staff A revealed he/she was unaware of the elevated blood pressures. The facility failed to adequately monitor blood pressure and report elevated blood pressures to the physician as directed in the facility's standing orders for resident #15, who received anti-hypertensive medications. - Resident #29's 5/1/13 order sheet revealed an order for Prinivil (an anti-hypertensive) 10mg (milligram) every day for Hypertension. Standing orders dated 4/4/13 directed staff to notify the primary physician if a resident's systolic blood pressure (top number) registered less than 90mmHg (millimeters of mercury) or greater than 170 mmHg and if the diastolic blood pressure (bottom number) registered less than 50mmHg or greater than 100 mmHg. Resident #29's vital sign record revealed the following: * 6/7/13: 81/52mmHg * 6/11/13: 85/66 mmHg The MAR (medication administration record) had	F 329		

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documentation that the resident received the Prinivil on 6/7/13 and 6/11/13, despite the resident ' s low blood pressure.

An observation on 6/25/13 at 8:06 a.m. MST (Mountain Standard Time), Resident #29 sat in the dining room at the table. He/she was alert to surroundings and fed self without difficulty.

During an interview on 6/26/13 at 10:24 a.m. MST, Administrative staff B revealed he/she was unaware of the low blood pressure readings. Staff B further revealed that if vital signs obtained did not meet the criteria of the standing order blood pressure parameters the charge staff should let the physician know by phone or fax.

During an interview on 6/26/13 at 11:20 a.m. MST, Administrative staff A revealed he/she was unaware of the elevated blood pressures.

The facility failed to adequately monitor blood pressures and report low blood pressures to the physician as directed in the facility's standing orders for resident #29, who received anti-hypertensive medications.

- Resident #8's 1/25/13 Annual MDS (Minimum Data Set) Assessment reported the resident sometimes understands others and sometimes made him/herself understood with severe cognitive impairment. The MDS reported the resident experienced no distressing behaviors, no delusions/hallucinations, and received no antipsychotic medications during the observation period.

Resident #8's 4/27/13 Quarterly MDS Assessment reported the resident sometimes

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F 329	Continued From page 39 understands, sometimes made him/herself understood, and experienced short and long term memory problems with severely impaired decision making skills. The MDS reported the resident displayed continuous inattention, disorganized thinking, psychomotor retardation, and altered level of consciousness. The MDS reported the resident experienced a moderate level of depression, delusions, and received antipsychotic medications for 7 of the 7 observation days. Resident #8's 1/25/13 Cognitive Loss CAA (Care Area Assessment) summary reported the resident had a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and due to poor memory recall, the resident often displayed behaviors such as attempting to stand up out of his/her chair that posed the resident as a fall risk. Resident #8's 5/9/13 care plan instructed staff that the resident had a diagnosis of Alzheimer's disease which affected the resident's memory and decision making skills. The care plan reported to monitor for potential side effects and/or adverse consequences related to the FDA (Food and Drug Administration) Black Box Warning for the use of Seroquel as "elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo [a substance containing no medication and prescribed or given to reinforce a patient's expectation to get well] Seroquel is not approved for elderly patients with dementia-related psychosis." The care plan informed staff that charge nurses documented behaviors on a behavioral monitoring sheet every shift and to notify the nurse if behaviors arise so the charge nurse can notify the physician.	F 329		

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F 329	Continued From page 40 Review of resident #8's physician's orders revealed an 3/1/13 order for Seroquel (an antipsychotic medication) 25 mg (milligrams) orally every night for dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances and a 4/4/13 order to increase Seroquel to 50 mg every night with a new indication of use of dementia with agitation and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). Review of resident #8's March 2013 and April 2013 "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed staff indicated the resident experienced "restlessness" and "insomnia" (inability to sleep) during multiple night shifts with interventions of "one to one" visits with no improvement. The form lacked evidence that staff identified targeted behaviors they hoped to improve/control with the use of Seroquel, and then lacked monitoring of the presence/absence of those specific behaviors. During an observation on 6/25/13 at 8:31 a.m. MST (Mountain Standard Time), resident #8 calmly sat at the dining room table and received assistance to eat his/her meal. During an interview on 6/26/13 at 7:56 a.m. MST, Direct Care Staff H reported the resident displayed no disturbing behaviors but occasionally moaned, though the resident reported he/she experienced no pain when Staff H asked. Staff H reported the resident did not sleep well at night as he/she usually slept at different times during the day and staff had difficulty keeping the resident awake during the day.	F 329		

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F 329	Continued From page 41 During an interview on 6/26/13 at 11:01 a.m. MST, Administrative Nursing Staff B reported that staff used the behavior form to document any distressing behaviors not related to medication use. Staff B verified that staff failed to identify targeted behaviors while the resident received Seroquel that they hoped to control or the presence/absence of those behaviors for resident #8. On 7/1/13 at 9:05 a.m. MST, Staff B verified the record lacked documentation of agitation and anxiety to support the start of or the increase of Seroquel and reported the clinical record lacked evidence of anxiety or agitation. The facility failed to ensure that resident #8 did not receive unnecessary medications as staff failed to adequately monitor for targeted behaviors while the resident received Seroquel. - Resident #22's 4/30/13 Annual MDS (Minimum Data Set) Assessment reported the resident understands others and made him/herself understood with moderately impaired cognition. The MDS reported the resident displayed no signs of depression, psychosis, or behaviors, and the resident received antipsychotic and antidepressant medication 7 of the 7 observation days. Resident #22's 5/1/13 Psychotropic Drug Use CAA (Care Area Assessment) summary reported the resident received Seroquel (an antipsychotic medication) and Zoloft (an antidepressant medication) due to past behavior of the resident becoming agitated with staff and his/her spouse if the resident's routine changed, no longer displayed such behaviors, and behaviors returned if the physician reduced the medication dosage.	F 329		

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F 329	Continued From page 42 Resident #22's 6/3/13 care plan instructed staff that the resident enjoyed spending time with his/her spouse but not group activities, received an antidepressant medication, and experienced confusion with a history of agitation. The care plan instructed staff to watch for worsening of his/her depression or agitation and notify the charge nurse so he/she could notify the physician. The care plan included the possible side effects and/or adverse consequences related to the FDA (Food and Drug Administration) Black Box Warning for the use of Seroquel and Zoloft, the charge nurse documented behaviors every shift, and the charge nurse notified the physicians of concerns that arose. Resident #22's 5/13/13 physician's orders included renewed orders for Zoloft 50 mg (milligrams) orally every day for depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) with a start date of 4/17/12 and Seroquel 25 mg orally every day with an indication of use as "unspecified psychosis" (a general term referring to a condition of the mind and loss of reality) with a start date of 9/5/12. Review of resident #22's June 2013 "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed the resident displayed no distressing behaviors during the month. The form lacked targeting behaviors they hoped to control with the use of Seroquel and Zoloft and lacked evidence of presence/absence of those specific behaviors. During an observation on 6/25/13 at 11:20 a.m. MST (Mountain Standard Time), resident #22 calmly ambulated independently in the hallway	F 329		

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F 329	Continued From page 43 with a cane as he/she conversed with his/her spouse. During an interview on 6/26/13 at 7:56 a.m. MST, Direct Care Staff H reported the resident displayed no distressing behaviors currently and over the past year. During an interview on 6/26/13 at 11:01 a.m. MST, Administrative Nursing Staff B reported the resident became agitated and upset with his/her spouse and staff in the past before he/she received Zoloft and Seroquel and currently the resident no longer displayed those behaviors. Staff B reported a lack of awareness of any symptoms of depression the resident displayed and reported that staff use the behavior form to document any distressing behaviors not related to medication use. Staff B verified the clinical record lacked evidence that staff monitored for the targeted behaviors for resident #22's use of Zoloft and Seroquel that staff hoped to control or the presence/absence of those specific behaviors. The facility failed to ensure resident #22 did not receive unnecessary medications as staff failed to adequately monitor for targeted behaviors while he/she received Zoloft and Seroquel. - Resident #19's 6/12/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported the resident sometimes understands others and sometimes made him/herself understood with severely impaired cognition. The MDS reported during the 7 observation days: * left the facility to an acute hospital on 5/2/13 * returned to the facility on 5/30/13 * displayed signs of moderately severe depression,	F 329		

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F 329	Continued From page 44 * experienced delusions, * displayed physical behaviors toward others 4 to 6 days * displayed verbal behaviors 1 to 3 days * rejected cares from staff 4 to 6 days * noted an acute worsening of the resident's clinical condition * received antipsychotic and antidepressant medications 7 days Resident #19's 6/13/13 Cognitive Loss CAA (Care Area Assessment) summary reported the resident transferred to an acute geriatric psychiatric hospital and since his/her return had acted agitated and experienced a functional decline with his/her activities of daily living. Resident #19's 6/13/13 Mood and Psychotropic Drug Use CAA summaries reported the resident received Wellbutrin and Celexa (both antidepressant medications) along with Seroquel (an antipsychotic medication) and noted the resident "is easily excitable and cries very easily" during the observation period. Resident #19's 3/4/13 care plan informed staff that the resident had a set routine and became anxious if told too far in advanced of upcoming appointments or events and tended to either hold onto his/her medications in his/her cheek and spit out the medications if not monitored closely. The care plan instructed staff to monitor for worsening anxiety and behaviors and notify the nurse who can then notify the physician. The care plan instructed staff to monitor for possible side effects and/or adverse consequences related to the FDA (Food and Drug Administration) Black Box Warnings for antidepressants and the use of Seroquel and that the charge nurse documented behaviors every shift and reported to the	F 329		

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F 329	Continued From page 45 physician if concerns arose. Resident #19's 5/30/13 readmission physician's orders included new orders for Wellbutrin XL (extended release) 150 mg (milligrams) orally every day for depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and Celexa 20 mg orally every day for depression. The readmission orders included a 5/30/13 order for Seroquel XR (extended release) 300 mg orally every day for bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) which increased the original 6/11/12 order of 100 mg daily. Review of resident #19's "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed: * April 2013: the resident displayed no distressing behaviors throughout the month even though the resident transferred to an acute geriatric psychiatric unit on 5/2/13 * May 2013: the resident displayed no distressing behaviors 5/1/13 and 5/2/13, staff documented the resident as "OOF" (out of the facility) between 5/3/13 and 5/30/13, and the resident displayed no distressing behaviors on 5/31/13 * June 2013: staff documented the resident displayed occasional "manic and hyper" behaviors with "one on one" and "redirection" interventions with no improvement. Review of resident #19's clinical record lacked evidence that staff monitored for targeted behaviors while the resident received Wellbutrin XL, Celexa, and Seroquel for behaviors they hoped to control and the presence/absence of those specific behaviors.	F 329		

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F 329	Continued From page 46 During an observation on 6/25/13 at 12:33 p.m. MST (Mountain Standard Time), resident #19 calmly cooperated with Direct Care Staff D and Licensed Nursing Staff C while he/she received assistance for toilet use. During an interview on 6/25/13 at 9:33 a.m. MST, Direct Care Staff I reported that resident yelled out in the facility's common areas, spit out his/her medications, and attempted to hit staff during cares prior to transferring to the acute geriatric psychiatric hospital on 5/2/13. Staff I reported the resident stopped walking due to weakness and rarely spoke after he/she returned to the facility on 5/30/13. Staff I reported he/she had heard that the resident's medication changed currently and noted the resident started to spit out medications again and still occasionally resisted cares. During an interview on 6/26/13 at 11:01 a.m. MST, Administrative Nursing Staff B reported the resident frequently resisted cares and spit out his/her medications prior to transferring to the acute geriatric psychiatric hospital and after his/her return to the facility, and lacked awareness that staff failed to document these distressing behaviors on the behavioral monitoring form. Staff B reported that staff use the behavior form to document any distressing behaviors not related to medication use. Staff B verified the clinical record lacked evidence that staff monitored for the targeted behaviors for resident #19's use of Wellbutrin, Celexa, and Seroquel that staff hoped to control or the presence/absence of those specific behaviors. The facility failed to ensure resident #19 did not receive unnecessary medications as staff failed	F 329		

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to adequately monitor for targeted behaviors while he/she received Wellbutrin, Celexa, and Seroquel.

- Resident #24's 4/30/13 Annual MDS (Minimum Data Set) Assessment reported the resident understands others and made him/herself understood with moderately impaired cognition. The MDS reported the resident displayed no behaviors, no delusions or hallucinations, and received antipsychotic and antidepressant medications for 7 of the 7 observation days.

Resident #24's 5/1/13 Cognitive Loss and Psychotropic Drug Use CAA (Care Area Assessment) summaries reported the resident received Zyprexa (an antipsychotic medication) and Zoloft (an antidepressant medication), that the resident had random episodes of confusion with "very agitated behaviors" prior to admission to the facility that now these medications controlled, and the behaviors reoccurred when the physician attempted to reduce these medication dosages.

Resident #24's 6/3/13 care plan instructed staff to monitor for the potential side effects and/or adverse consequences of the FDA (Food and Drug Administration) Black Box Warnings while the resident received Zyprexa and Zoloft. The care plan instructed staff to monitor for worsening of his/her overall condition, for talk related suicide, the charge nurse documented behaviors on a behavioral monitoring sheet every shift, and informed staff to notify the charge nurse of any concerns so that he/she could notify the physician.

Resident #24's 5/13/13 physician's orders included renewed orders for Zyprexa (an

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antipsychotic medication) 2.5 mg (milligrams) orally twice a day for dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances with a start date of 7/2/12 and Zoloft (an antidepressant medication) 50 mg orally every night for depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) with a start date of 5/27/12.

Review of resident #24's June 2013 "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed the resident experienced one episode of paranoia on the night shift with an intervention of "one to one" visit and no change in outcome. The form lacked mention of the target behavior they hoped to control while the resident received Zyprexa and Zoloft, and lacked monitoring of those specific behaviors.

During an observation on 6/25/13 at 10:31 a.m. MST (Mountain Standard Time), resident #24 sat calmly in his/her room as he/she conversed with his/her spouse.

During an interview on 6/26/13 at 7:56 a.m. MST, Direct Care Staff H reported resident #24 preferred a set routine and became upset and yelled out paranoia-type statements after delayed appointments such as getting his/her hair done later than expected.

During an interview on 6/26/13 at 11:01 a.m. MST, Administrative Nursing Staff B reported the resident made paranoia-type statements and became upset if he/she encountered changes in his/her routine but lacked awareness of any symptoms of depression that the resident displayed. Staff B reported that staff use the

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behavior form to document any distressing behaviors not related to medication use. Staff B verified the clinical record lacked evidence that staff monitored for the targeted behaviors for resident #24's use of Zyprexa and Zoloft that staff hoped to control or the presence/absence of those specific behaviors.

The facility failed to ensure resident #24 did not receive unnecessary medications as staff failed to adequately monitor for targeted behaviors while he/she received Zyprexa and Zoloft.

- Resident #17's 5/13/13 physician order sheet included a diagnosis of hypertension (elevated blood pressure) and orders for Propanolol 10 mg (milligrams) 1 1/2 tablets twice a day and Lasix 60 mg. daily (both anti-hypertensive medications used to lower the blood pressure).

Resident #17's 3/23/13 quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 10 which indicated moderately impaired cognition and required limited assistance of 1 person for activities of daily living. The resident received diuretic therapy during 7 days of the assessment period.

The resident's 9/20/12 CAA (care area assessment) summary for activities of daily living revealed the resident required 1 person assistance with a walker for mobility.

Resident #17's 4/2/13 care plan included interventions and boxed warnings related to the use of Propanolol and Lasix.

Standing orders dated 4/4/13 directed staff to

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F 329	Continued From page 50 notify the primary physician if a resident's systolic blood pressure (top number) registered less than 90 mmHg (millimeters of mercury) or greater than 170 mmHg and if the diastolic blood pressure (bottom number) registered less than 50 mmHg or greater than 100 mmHg. Review of resident #17's vital signs record revealed a blood pressure of 182/80 on 4/22/13 and 189/98 on 4/26/13. Review of the clinical record lacked any documentation that staff notified the physician of the elevated blood pressures. During an observation on 6/25/13 at 5:30 p.m., resident #17 ambulated in the hall with a steady gait with assistance of direct care staff P using a gait belt and a walker. An interview on 6/25/13 at 12:28 p.m. with licensed nurse B confirmed the nurses used the blood pressure parameters in the facility standing orders for physician notification of abnormal vital signs. He/she stated when a resident had an elevated blood pressure, physician notification should be documented in the nurses' notes. Licensed nurse B confirmed resident #17's clinical record lacked documentation of notification of the resident's elevated blood pressures on 4/22/13 and 4/26/13. The facility failed to adequately monitor resident #17's blood pressures according to the parameters stated in the standing orders. Resident #17 received anti-hypertensive medications, Propanolol and Lasix.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		

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F 334	Continued From page 51 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334		

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F 334	Continued From page 52 (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This Requirement is not met as evidenced by: The facility reported a census of 26 residents with 5 residents sampled for review of immunizations. Based on interview and record review, the facility failed to ensure that 4 of the 5 sampled residents and/or their representatives received education regarding the benefits and potential side effects of the immunization and the opportunity to refuse prior to administration of the 2012-2013 influenza vaccination and failed to document staff provided education in 3 of the 5 sampled residents' clinical record. (Residents #22, #4, #24, and #20) Findings included: - Review of resident #22, #4, and #24's clinical record lacked evidence that the resident and/or	F 334		

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representative received education regarding the benefits and potential side effects for the 2012-2013 influenza immunization. Each of these residents' clinical record revealed they received the influenza vaccine on 10/18/12 in his/her left upper arm.

Review of resident #20's clinical record revealed the resident received education regarding the benefits and potential side effects of the 2012-2013 influenza immunization on 11/12/12. Resident #20's clinical record revealed the resident received the influenza vaccine on 10/18/12 in the left upper arm (25 days prior to receiving education and the opportunity to refuse the vaccine).

During an interview on 6/24/13 at 4:39 p.m. MST (Mountain Standard Time), Administrative Nursing Staff B reported he/she failed to provide education to residents/representative related to the 2012-2013 influenza vaccine prior to administration of multiple residents on 10/18/12. Staff B reported he/she mailed out a consent form with indication that staff provided education to residents #22, 20, 4, and 24's representatives approximately a month after he/she administered the vaccine and did not receive the form back from #22, #4, and #24's representatives. Staff B verified the clinical record lacked documentation that staff provided education prior to administering the influenza vaccine and verified he/she failed to provide an opportunity to refuse the vaccine prior to administration.

The facility's "Policy and Procedure Immunizations", last reviewed on 6/24/13, instructed staff to "make sure that each resident who wishes to receive any vaccine or immunization is provided with education about the

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F 334	Continued From page 54 vaccine or immunization prior to administration and that it is documented in the resident's chart". The facility failed to ensure residents #22, #20, #4, and #22 and/or their representative received education prior to administration of the 2012-2013 influenza vaccine to provide an opportunity to refuse and failed to document that staff provided education in residents #22, #4, and #24's clinical record.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 26 residents with one kitchen and dining room that served all the residents. Based on observation, interview, and record review the facility failed to prepare and transport food under sanitary conditions. Findings included: - Observation on 6-24-13 at 10:00 a.m. revealed the following: Dietary staff K washed his/her hands and put on clean gloves in preparation of making the pureed diets. He/she then tore apart 3 pieces of cooked pork cutlets and put those	F 371		

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pieces into a blender. He/she added broth to the meat and put the blender lid on. Dietary staff K then turned on the blender with the same gloves. After blending the broth and meat mixture, dietary staff K then broke more pieces of pork cutlets and added those to the pureed mixture. He/she did not change his/her gloves during the preparation of the pureed meat after touching the blender or the container with the broth.

During an interview on 6-26-13 at 1:15 p.m., dietary manager L stated he/she expected staff to change gloves after handling kitchen equipment before touching foods.

Review of the facility ' s Use of Plastic Gloves Policy dated 3-22-12 states, " Anytime a contaminated surface is touched, the gloves must be changed ...during food preparations, as often as necessary to removed soil and contamination and to prevent cross contamination when changing tasks. "

The facility failed to prepare food under sanitary conditions.

- An observation on 6-25-13 at 11:55 a.m. revealed nursing staff I transported resident #31's room tray to his/her room down a resident hallway on an over the bed table. The plate on the room try contained the following: ground meat, broccoli, salad, sweet potatoes, and iced tea in a glass. Both the plate and the glass remained uncovered during transportation down the hallway to the resident's room.

Another observation on 6-26-13 at 12:00 p.m. revealed nursing staff D transported room trays for residents #27, #29, and #31 down the residents' hallway again on an over the bed

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F 371	Continued From page 56 table. All the plates contained ground or baked chicken, baked potatoes, green beans, and a vegetable salad. The residents also received iced tea with their lunches. Again all the plates and glasses remained uncovered during the transportation down the hallway to the residents ' rooms. During an interview on 6-26-13 at 1:15 pm, dietary staff L stated he/she expected dietary staff to cover all plates of food with plate covers and glasses with plastic or the trays kept in the carts for transport to the residents ' rooms. During an interview on 6-26-13 at 1:30 pm, administrative nurse A stated he/she expected nursing and dietary staff to cover all food and drinks before transporting them to the residents ' rooms. Review of the facility's Timely Meal Service policy dated 11-29-12 states, " Room trays will be prepared at Long Term Care by dietary and delivered to the residents by the nursing staff. Meals will be placed in the cart ...Food service personnel deliver the cart to the Long Term Care ... " . The facility failed to transport food under sanitary conditions.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		

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F 425	Continued From page 57 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This Requirement is not met as evidenced by: The facility reported a census of 26 residents with 10 residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure 1 of the 10 sampled residents received all drugs and biologicals to meet the needs of that resident as staff failed to ensure the resident received a Fentanyl patch as ordered by the physician. (Resident #24) Findings included: - Resident #24's 4/30/13 Annual MDS (Minimum Data Set) Assessment reported the resident understands others and made him/herself understood with moderate impaired cognition. The MDS reported the resident reported he/she experienced no pain during the observation period. Resident #24's 5/1/13 Cognitive Loss CAA (Care Area Assessment) summary reported the	F 425		

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resident stated his/her pain felt controlled with the current treatment.

Resident #24's 6/3/13 care plan instructed staff to note the resident received a medicated patch for pain due to pain from cancer that needed to stay on the resident's skin at all times. The care plan instructed that the patch needed to be changed on the scheduled days and at the scheduled time to get the best coverage to control his/her pain.

Resident #24's 5/13/13 physician's orders included renewal of a 4/17/12 order for Fentanyl patch (a pain medication) to change every 72 hours for chronic pain due to cancer of a reproductive organ.

Review of resident #24's June MAR (Medication Administration Record) revealed that staff circled initials for the Fentanyl patch on 6/13/13 and 6/16/13 and noted on the back of the MAR "not available" on both dates. The MAR noted staff failed to administer the Fentanyl patch between 6/10/13 and 6/19/13. With removal of the 6/10/13 patch on 6/12/13, staff failed to administer the Fentanyl patch for 7 days without the benefit of pain relief. Between 6/10/13 and 6/19/13, staff administered no PRN (as needed) medications and review of the nurses' notes revealed no documentation related to the resident's pain.

Lexi-Comp's Drug Reference Handbook, Geriatric Dosage Handbook, 16th edition, pages 675 through 684, instructed to use Fentanyl transdermal patches for chronic pain, change the patch every 72 hours, and "opioid withdrawal symptoms are possible" if staff abruptly stopped administration of the patches as ordered by the physician.

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During an observation on 6/25/13 at 11:39 a.m. MST (Mountain Standard Time), resident #24 ambulated independently in the hallway and showed no outward signs of pain such as grimacing, moaning, or guarding body parts.

During an interview on 6/24/13 at 11:31 a.m. MST, resident #24 denied having pain currently or in the recent month.

During an interview on 6/26/13 at 10:41 a.m. MST, Administrative Nursing Staff B reported that a lack of awareness that staff failed to administer the Fentanyl patch on 6/16/13 and 6/19/13. Staff B reported that resident #24 had a history of denying pain when asked by staff then called his/her family to complain that he/she felt severe pain, so when the resident denied pain issues during the MDS interview he/she relied on family information to know if the resident's pain felt controlled. Staff B reported that since the physician ordered the patch on a scheduled basis, the pharmacy sent the medication in advance as soon as staff reported the need to refill the supply to the pharmacy. Staff B verified the facility failed to ensure the resident received his/her Fentanyl patch as ordered by the physician.

During an interview on 6/26/13 at 2:21 p.m. MST, Consultant F reported he/she knew that pharmacy did not refill resident #24's Fentanyl patch by 6/16/13 due to need of a new script from the physician. Consultant F reported the facility nursing staff held responsibility to contact the physician for the new script, which did not get written until 6/18/13 at which time the pharmacy filled and delivered the patches to the facility.

The facility failed to ensure that resident #24

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F 425	Continued From page 60 received all drugs and biologicals as staff failed to administer his/her physician ordered Fentanyl patches on 6/13/13 and 6/16/13.	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility reported a census of 26 with 10 residents reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure that the Consultant Pharmacist identified drug irregularities for 7 of 10 residents sampled for unnecessary medications when staff failed to monitor target behaviors for resident #8, 24, 22 and 19, who received psychoactive medications and also failed to adequately monitor blood pressures for residents #15, #29, and #9, who received anti-hypertensive medications. Findings included: - Resident #15 5/1/13 medication order sheet revealed orders for: Toprol (an anti-hypertensive used to lower blood pressure) 25mg (milligrams) every day for Hypertension (elevated blood pressure).	F 428		

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F 428	Continued From page 61 Lisinopril (an anti-hypertensive) 50mg every day for Hypertension Resident #15's 4/23/13 Quarterly MDS (minimum data set) revealed the resident had a BIMS (brief interview for mental status) score which indicated severe cognitive impairment. Resident #15's 5/9/13 revised nursing care plan advised staff to monitor blood pressure parameters for the use of Toprol. Standing orders dated 4/4/13 directed staff to notify the primary physician if a resident's systolic blood pressure (top number) registered less than 90mmHg (millimeters of mercury) or greater than 170 mmHg and if the diastolic blood pressure (bottom number) registered less than 50mmHg or greater than 100 mmHg. The clinical record revealed the following blood pressure readings with none of the readings. * 2/15/13: 194/87mmHg * 2/15/13: 197/106 mmHg * 4/7/13: 186/89 mmHg * 4/30/13: 183/186 mmHg * 5/4/13: 189/97 mmHg * 5/20/13: 191/190 mmHg * 5/31/13: 192/91 mmHg * 6/1/13: 185/104 mmHg Review of the clinical record revealed a lack of documentation in the nurse's notes or documentation of physician notification of the elevated blood pressures, above the parameters established in the facility standing orders. Resident #15 ' s monthly medication reviews dated 6/27/12, 7/18/12, 8/16/12, 9/26/12,	F 428		

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F 428	Continued From page 62 10/30/12, 11/30/12, 12/28/12, 1/31/13, 3/30/13, 4/30/13 and 5/31/13 revealed no notification of blood pressure elevations to the physician or director of nursing. An observation on 6/25/13 at 4:15p.m.MST (Mountain Standard Time), Resident #15 ambulated down the hallway independently, his/her gait remained steady. During an interview on 6/26/13 at 10:14 a.m. MST, Administrative staff B revealed that if a resident ' s blood pressure reading registers out of the parameters set by the physician, then staff should notify the physician by phone or fax. During an interview on 6/26/13 at 2:32 p.m. MST, Consultant Pharmacist F revealed he/she looked at the blood pressure medications and the blood pressure monitoring system and looked for trends, but was unaware of the elevated blood pressures or lack of physician notifications. The facility failed to ensure the consultant pharmacist identified drug irregularities related to resident #15 ' s elevated blood pressures while receiving anti-hypertensive medications. - Resident #29's 5/1/13 order sheet revealed an order for Prinivil (an anti-hypertensive) 10mg (milligram) every day for Hypertension. Standing orders dated 4/4/13 directed staff to notify the primary physician if a resident ' s systolic blood pressure (top number) registered less than 90mmHg (millimeters of mercury) or greater than 170 mmHg and if the diastolic blood pressure (bottom number) registered less than 50mmHg or greater than 100 mmHg.	F 428		

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F 428	Continued From page 63 Resident #29 ' s monthly medication review dated 4/30/13 and 6/1/13 revealed no notification of resident ' s low blood pressure to the physician or director of nursing. Resident #29 ' s vital sign record revealed the following: * 6/7/13: 81/52mmHg * 6/11/13: 85/66 mmHg The MAR (medication administration record) had documentation that the resident received the Prinivil on 6/7/13 and 6/11/13, despite the resident ' s low blood pressure. An observation on 6/25/13 at 8:06 a.m. MST (Mountain Standard Time), Resident #29 sat in the dining room at the table. He/she was alert to surroundings and fed self without difficulty. During an interview on 6/26/13 at 10:24 a.m. MST, Administrative staff B revealed he/she was unaware of the low blood pressure readings. Staff B further revealed that if vital signs obtained did not meet the criteria of the standing order blood pressure parameters the charge staff should let the physician know by phone or fax. During an interview on 6/26/13 at 2:32 p.m. MST, Consultant Pharmacist F revealed he/she look3e at the blood pressure medications and the blood pressure monitoring system and looked for trends, but was unaware of the low blood pressures or lack of physician notifications. The facility failed to ensure the consultant pharmacist identified drug irregularities related to resident #15 ' s low blood pressures while receiving anti-hypertensive medications.	F 428		

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F 428	Continued From page 64 - Resident #8's 1/25/13 Annual MDS (Minimum Data Set) Assessment reported the resident sometimes understands others and sometimes made him/herself understood with severe cognitive impairment. The MDS reported the resident experienced no distressing behaviors, no delusions/hallucinations, and received no antipsychotic medications during the observation period. Resident #8's 4/27/13 Quarterly MDS Assessment reported the resident sometimes understands, sometimes made him/herself understood, and experienced short and long term memory problems with severely impaired decision making skills. The MDS reported the resident displayed continuous inattention, disorganized thinking, psychomotor retardation, and altered level of consciousness. The MDS reported the resident experienced a moderate level of depression, delusions, and received antipsychotic medications for 7 of the 7 observation days. Resident #8's 1/25/13 Cognitive Loss CAA (Care Area Assessment) summary reported the resident had a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and due to poor memory recall, the resident often displayed behaviors such as attempting to stand up out of his/her chair that posed the resident as a fall risk. Resident #8's 5/9/13 care plan instructed staff that the resident had a diagnosis of Alzheimer's disease which affected the resident's memory and decision making skills. The care plan reported to monitor for potential side effects and/or adverse consequences related to the FDA	F 428		

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(Food and Drug Administration) Black Box Warning for the use of Seroquel as "elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo [a substance containing no medication and prescribed or given to reinforce a patient's expectation to get well] Seroquel is not approved for elderly patients with dementia-related psychosis." The care plan informed staff that charge nurses documented behaviors on a behavioral monitoring sheet every shift and to notify the nurse if behaviors arise so the charge nurse can notify the physician.

Review of resident #8's physician's orders revealed an 3/1/13 order for Seroquel (an antipsychotic medication) 25 mg (milligrams) orally every night for dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances and a 4/4/13 order to increase Seroquel to 50 mg every night with a new indication of use of dementia with agitation and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

Review of resident #8's March 2013 and April 2013 "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed staff indicated the resident experienced "restlessness" and "insomnia" (inability to sleep) during multiple night shifts with interventions of "one to one" visits with no improvement. The form lacked evidence that staff identified targeted behaviors they hoped to improve/control with the use of Seroquel, and then lacked monitoring of the presence/absence of those specific behaviors.

Review of resident #8's pharmacy consultant's monthly medication review between 3/30/13 and

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F 428	Continued From page 66 5/27/13, the pharmacy consultant failed to document he/she reviewed the resident's clinical record for targeted behavioral monitoring while the resident received Seroquel. During an observation on 6/25/13 at 8:31 a.m. MST (Mountain Standard Time), resident #8 calmly sat at the dining room table and received assistance to eat his/her meal. During an interview on 6/26/13 at 2:21 p.m. MST, Consultant F reported that he/she lacked awareness that staff needed to monitor residents, such as resident #8, for targeted behavioral monitoring while taking Seroquel. The facility failed to ensure that the pharmacy consultant reported irregularities to the attending physician and director of nursing that staff failed to monitor resident #8's targeted behaviors while he/she received Seroquel. - Resident #22's 4/30/13 Annual MDS (Minimum Data Set) Assessment reported the resident understands others and made him/herself understood with moderately impaired cognition. The MDS reported the resident displayed no signs of depression, psychosis, or behaviors, and the resident received antipsychotic and antidepressant medication 7 of the 7 observation days. Resident #22's 5/1/13 Psychotropic Drug Use CAA (Care Area Assessment) summary reported the resident received Seroquel (an antipsychotic medication) and Zoloft (an antidepressant medication) due to past behavior of the resident becoming agitated with staff and his/her spouse if the resident's routine changed, no longer displayed such behaviors, and behaviors returned	F 428		

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F 428	Continued From page 67 if the physician reduced the medication dosage. Resident #22's 6/3/13 care plan instructed staff that the resident enjoyed spending time with his/her spouse but not group activities, received an antidepressant medication, and experienced confusion with a history of agitation. The care plan instructed staff to watch for worsening of his/her depression or agitation and notify the charge nurse so he/she could notify the physician. The care plan included the possible side effects and/or adverse consequences related to the FDA (Food and Drug Administration) Black Box Warning for the use of Seroquel and Zoloft, the charge nurse documented behaviors every shift, and the charge nurse notified the physicians of concerns that arose. Resident #22's 5/13/13 physician's orders included renewed orders for Zoloft 50 mg (milligrams) orally every day for depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) with a start date of 4/17/12 and Seroquel 25 mg orally every day with an indication of use as "unspecified psychosis" (a general term referring to a condition of the mind and loss of reality) with a start date of 9/5/12. Review of resident #22's June 2013 "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed the resident displayed no distressing behaviors during the month. The form lacked targeting behaviors they hoped to control with the use of Seroquel and Zoloft and lacked evidence of presence/absence of those specific behaviors. Review of resident #22's pharmacist consultant	F 428		

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monthly medication review between 6/27/12 and 5/27/13, the pharmacist consultant failed to document that he/she reviewed the resident's clinical record for targeted behavioral monitoring while the resident received Seroquel and Zoloft.

During an observation on 6/25/13 at 11:20 a.m. MST (Mountain Standard Time), resident #22 calmly ambulated independently in the hallway with a cane as he/she conversed with his/her spouse.

During an interview on 6/26/13 at 2:21 p.m. MST, Consultant F reported that he/she lacked awareness that staff needed to monitor residents, such as resident #22, for targeted behavioral monitoring while taking Seroquel and Zoloft.

The facility failed to ensure that the pharmacy consultant reported irregularities to the attending physician and director of nursing that staff failed to monitor resident #'22s targeted behaviors while he/she received Seroquel and Zoloft.

- Resident #19's 6/12/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported the resident sometimes understands others and sometimes made him/herself understood with severely impaired cognition. The MDS reported during the 7 observation days:
* left the facility to an acute hospital on 5/2/13
* returned to the facility on 5/30/13
* displayed signs of moderately severe depression,
* experienced delusions,
* displayed physical behaviors toward others 4 to 6 days
* displayed verbal behaviors 1 to 3 days
* rejected cares from staff 4 to 6 days
* noted an acute worsening of the resident's

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F 428	Continued From page 69 clinical condition * received antipsychotic medications 7 days Resident #19's 6/13/13 Cognitive Loss CAA (Care Area Assessment) summary reported the resident transferred to an acute geriatric psychiatric hospital and since his/her return had acted agitated and experienced a functional decline with his/her activities of daily living. Resident #19's 6/13/13 Mood and Psychotropic Drug Use CAA summaries reported the resident received Seroquel (an antipsychotic medication) and noted the resident "is easily excitable and cries very easily" during the observation period. Resident #19's 3/4/13 care plan informed staff that the resident had a set routine and became anxious if told too far in advanced of upcoming appointments or events and tended to either hold onto his/her medications in his/her cheek and spit out the medications if not monitored closely. The care plan instructed staff to monitor for worsening anxiety and behaviors and notify the nurse who can then notify the physician. The care plan instructed staff to monitor for possible side effects and/or adverse consequences related to the FDA (Food and Drug Administration) Black Box Warnings for the use of Seroquel and that the charge nurse documented behaviors every shift and reported to the physician if concerns arose. Resident #19's 5/30/13 readmission physician's orders included orders to increase Seroquel XR (extended release) 300 mg orally every day for bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) which increased the original 6/11/12 order of 100 mg daily.	F 428		

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F 428	Continued From page 70 Review of resident #19's "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed: * April 2013: the resident displayed no distressing behaviors throughout the month even though the resident transferred to an acute geriatric psychiatric unit on 5/2/13 * May 2013: the resident displayed no distressing behaviors 5/1/13 and 5/2/13, staff documented the resident as "OOF" (out of the facility) between 5/3/13 and 5/30/13, and the resident displayed no distressing behaviors on 5/31/13 Review of resident #19's clinical record lacked evidence that staff monitored for targeted behaviors while the resident received Seroquel for behaviors they hoped to control and the presence/absence of those specific behaviors. Review of resident #19's pharmacist consultant monthly medication reviews between 6/27/12 and 4/30/13, the pharmacist consultant failed to document that he/she reviewed the resident's clinical record for targeted behavioral monitoring while the resident received Seroquel prior to his/her transfer to the acute hospital. On 5/27/13, the pharmacist consultant noted that the resident transferred to an acute geriatric psychiatric hospital. During an observation on 6/25/13 at 12:33 p.m. MST (Mountain Standard Time), resident #19 calmly cooperated with Direct Care Staff D and Licensed Nursing Staff C while he/she received assistance for toilet use. During an interview on 6/26/13 at 2:21 p.m. MST, Consultant F reported that he/she lacked awareness that staff needed to monitor residents,	F 428		

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such as resident #19, for targeted behavioral monitoring while taking Seroquel.

The facility failed to ensure that the pharmacy consultant reported irregularities to the attending physician and director of nursing that staff failed to monitor resident #19's targeted behaviors while he/she received Seroquel.

- Resident #24's 4/30/13 Annual MDS (Minimum Data Set) Assessment reported the resident understands others and made him/herself understood with moderately impaired cognition. The MDS reported the resident displayed no behaviors, no delusions or hallucinations, and received antipsychotic and antidepressant medications for 7 of the 7 observation days.

Resident #24's 5/1/13 Cognitive Loss and Psychotropic Drug Use CAA (Care Area Assessment) summaries reported the resident received Zyprexa (an antipsychotic medication) and Zoloft (an antidepressant medication), that the resident had random episodes of confusion with "very agitated behaviors" prior to admission to the facility that now these medications controlled, and the behaviors reoccurred when the physician attempted to reduce these medication dosages.

Resident #24's 6/3/13 care plan instructed staff to monitor for the potential side effects and/or adverse consequences of the FDA (Food and Drug Administration) Black Box Warnings while the resident received Zyprexa and Zoloft. The care plan instructed staff to monitor for worsening of his/her overall condition, for talk related suicide, the charge nurse documented behaviors on a behavioral monitoring sheet every shift, and informed staff to notify the charge nurse of any

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concerns so that he/she could notify the physician.

Resident #24's 5/13/13 physician's orders included renewed orders for Zyprexa (an antipsychotic medication) 2.5 mg (milligrams) orally twice a day for dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances with a start date of 7/2/12 and Zoloft (an antidepressant medication) 50 mg orally every night for depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) with a start date of 5/27/12.

Review of resident #24's June 2013 "Depression/Behavioral Monitoring Intervention Monthly Flow Record" revealed the resident experienced one episode of paranoia on the night shift with an intervention of "one to one" visit and no change in outcome. The form lacked mention of the target behavior they hoped to control while the resident received Zyprexa and Zoloft, and lacked monitoring of those specific behaviors.

Review of resident #24's pharmacy consultant's monthly medication review between 6/27/12 and 5/27/13 lacked documentation that he/she reviewed the resident's clinical record for targeted behaviors while the resident received Zyprexa and Zoloft.

During an observation on 6/25/13 at 10:31 a.m. MST (Mountain Standard Time), resident #24 sat calmly in his/her room as he/she conversed with his/her spouse.

During an interview on 6/26/13 at 2:21 p.m. MST, Consultant F reported that he/she lacked

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awareness that staff needed to monitor residents, such as resident #24, for targeted behavioral monitoring while taking Zyprexa and Zoloft.

The facility failed to ensure that the pharmacy consultant reported irregularities to the attending physician and director of nursing that staff failed to monitor resident #24's targeted behaviors while he/she received Zyprexa and Zoloft.

- Resident #17's 5/13/13 physician order sheet included a diagnosis of hypertension (elevated blood pressure) and orders for Propanolol 10 mg (milligrams) 1 1/2 tablets twice a day and Lasix 60 mg. daily (both anti-hypertensive medications used to lower the blood pressure).

Resident #17's 3/23/13 quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 10 which indicated moderately impaired cognition and required limited assistance of 1 person for activities of daily living. The resident received diuretic therapy during 7 days of the assessment period.

The resident's 9/20/12 CAA (care area assessment) summary for activities of daily living revealed the resident required 1 person assistance with a walker for mobility.

Resident #17's 4/2/13 nursing care plan included interventions and boxed warnings related to the use of Propanolol and Lasix.

Standing orders dated 4/4/13 directed staff to notify the primary physician if a resident's systolic blood pressure (top number) registered less than

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90 mmHg (millimeters of mercury) or greater than 170 mmHg and if the diastolic blood pressure (bottom number) registered less than 50 mmHg or greater than 100 mmHg.

Review of resident #17's vital signs record revealed a blood pressure of 182/80 on 4/22/13 and 189/98 on 4/26/13. Review of the clinical record lacked any documentation that staff notified the physician of the elevated blood pressures.

Review of consultant pharmacist F 4/30/13 monthly medication review lacked identification of resident #17's elevated blood pressures.

During an observation on 6/25/13 at 5:30 p.m. MST, resident #17 ambulated in the hall with a steady gait with assistance of direct care staff P using a gait belt and a walker.

An interview on 6/25/13 at 12:28 p.m. MST with licensed nurse B confirmed the nurses used the blood pressure parameters in the facility standing orders for physician notification of abnormal vital signs. He/she stated when a resident had an elevated blood pressure, physician notification should be documented in the nurses' notes. Licensed nurse B confirmed resident #17's clinical record lacked documentation of notification of the resident's elevated blood pressures on 4/22/13 and 4/26/13.

During an interview on 6/25/13 at 2:22 p.m. MST, consultant pharmacist F stated he/she looked at trends of elevated blood pressures and was not aware of resident #17's elevated blood pressures on 4/22/13 and 4/26/13.

The facility failed to ensure the consultant

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F 428	Continued From page 75 pharmacist identified drug irregularities related to blood pressure monitoring for resident #17 who received antihypertensive medications.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 76 This Requirement is not met as evidenced by: The facility reported a census of 26 residents. Based on observation, interview, and record review, the facility failed to store drugs and biologics under proper temperature controls, which affected 1 of the 26 residents. (Resident #2) Findings included: - An observation of the facilities nursing work room on 6/24/2013 at 11:00 a.m., for the Sunflower Hall revealed resident #2's Forteo (injectable medication for osteoporosis) stored in the refrigerator. The internal temperature presented as 46 degrees F (Fahrenheit) on 6/24/2013 and 50 degrees F on 6/25/2013. Review of the refrigerator temperature log revealed a temperature of 47 degrees F on 6/11/2013 and 48 degrees F on 6/19/2013. The log also revealed staff checked the internal refrigerator temperature 10 out of 24 days with 13 days blank. Review of the Forteo manufacturer's information (www.forteo.com <http://www.forteo.com>) included the following: The medication should be stored between 36 to 46 degrees F. Discard after 28 days. Discard if frozen. Contact e.Lilly if left out of the refrigerator. Review of the facilities "Medication Temperature Policy and Procedure" dated 8/11/2008 instructed the night shift [staff] to check the refrigerator temperatures daily and to keep the temperature range between 35 and 46 degrees F. Interview with administrative nurse A on	F 431		

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F 431	Continued From page 77 8/26/2013 at 1:30 p.m. revealed he/she was not aware the temperatures of the refrigerators used for medication storage were not within an acceptable range. Nurse A lacked awareness of the required temperatures for the storage of the medication Forteo. The facility failed to store drugs and biologics under proper temperature controls, which affected resident #2.	F 431		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: The facility had a census of 26 residents with one kitchen that served all the residents. Based on observation, interview, and record review the facility failed to keep a sanitary environment within the kitchen by not keeping the floors clean. Findings included: - During initial tour on 6-24-13 at 10:00 a.m. and subsequent visits to the facility kitchen on 6-25-13 at 11:15 a.m. and on 6-26-13 at 2:00 p.m. revealed large darkened areas of wax buildup and grime around the following: the legs of the kitchen dishwasher, the legs of the clean dish racks in the dishwasher room, the legs of the cabinets and sinks in the preparation area in the kitchen.	F 465		

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F 465	Continued From page 78 During an interview on 6-26-13 at 5:00 pm, Dietary staff L stated staff sweep and mop the kitchen floors daily. He/she further stated he/she did not have mopping and sweeping the floors on the cleaning schedules. He/she confirmed the kitchen floor needed a thorough cleaning to remove the darkened areas. During an interview on 6-25-13 at 5:30 pm, maintenance staff G confirmed the condition of the kitchen floors. He/she stated the floors were deep cleaned around a year ago and scheduled to be deep cleaned again next month in July. He/she further stated he/she did not keep any cleaning schedules that pertained to the deep cleaning of the kitchen floor. He/she stated the floor needed to be cleaned more often than yearly. Record review of the kitchen cleaning schedules revealed no scheduled wax removal or deep cleaning of the kitchen floors. The facility failed to keep a sanitary environment within the kitchen by not keeping the floors clean.	F 465		